

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT**FACILITIES DEVELOPMENT DIVISION**1600 9th Street, Room 420 ~ Sacramento, California 958141831 9th Street ~ Sacramento, California 95814

107 South Broadway, Room 7106 ~ Los Angeles, California 90012

Phone (916) 654-3362

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Phone (213) 897-0166

FAX (213) 897-0168 (LA/Orange Co's Only)

www.oshpd.state.ca.us/fdd

**ALTERNATE METHOD OF COMPLIANCE**

| | | | | | | | |
|----------|---|---------|------------|------------------------------|---|--------------------------|--|
| A | Name of Facility: | | | OSHPD # | | | |
| | Address - Street: | | | SUBMITTAL # | | | |
| | City: | County: | Zip: | FACILITY ID # | | | |
| | Title of Project: | | | DATE: | | | |
| B | APPLICATION MADE BY – Name: | | Signature: | | <input type="checkbox"/> Alt Method of Compliance <input type="checkbox"/> Program Flex <input type="checkbox"/> Alt Method of Protection <input type="checkbox"/> _____ | | |
| | Title | | | | | | |
| | Address: | | | | | | |
| | City: | State: | Zip: | | | | |
| | Phone: | | FAX: | | Local authority approval required. | | |
| | Who is to be known as the: <input type="checkbox"/> Legal Owner/Administrator <input type="checkbox"/> Agent for the Legal Owner/Administrator/Letter of Authorization must be attached | | | | | | |
| C | Type of Facility: <input type="checkbox"/> General Acute Care <input type="checkbox"/> Skilled Nursing (SNF) and Intermediate Care Facility (ICF) <input type="checkbox"/> Psychiatric Hospital <input type="checkbox"/> Other | | | | | | |
| | | | | | | | |
| D | Description of proposal : | | | | | Applicable Code Section | |
| | | | | | | | |
| | Reason : | | | | | | |
| | List of Enclosures: | | | | | | |
| E | OSHPD RECOMMENDATIONS | | | OK | NO | N/A | DHS LICENSING AND CERTIFICATION RECOMMENDATIONS: <input type="checkbox"/> OK <input type="checkbox"/> NO <input type="checkbox"/> N/A Signature _____ Date _____ Remarks: |
| | Architectural Review | Date | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Structural Review | Date | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Mechanical Review | Date | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Electrical Review | Date | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | FLSO Review | Date | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | | | | | | | |
| F | <input type="checkbox"/> Approved <input type="checkbox"/> Conditional Approval <input type="checkbox"/> Denied | | | Signature: _____ Date: _____ | | | |
| | | | | | | | |

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INSTRUCTIONS FOR ALTERNATE METHOD OF COMPLIANCE (OSH-FD-126)

- A Enter name as it appears on the facility license. Enter street address, city, county and zip code (five or nine digit zip code as applicable).

Title of project - enter a brief descriptive statement of the work to be performed.

Enter the Office of Statewide Health Planning and Development (OSHPD) project number and OSHPD Facility identification number.

- B This application is to be signed by the legal owner or administrator of the facility, or agent. Indicate in the appropriate boxes the name, signature, title, address, phone and fax number of the applicant.

Check the box type of (Alternate Method) review required.

- C Check the box for type facility.

- D Description of proposal - provide complete description of proposed alternate and applicable code section.

Reason for change - List or describe the reasons the items above are requested.

List of enclosures - List the enclosures or attachments. Such enclosures must include architect's title block, facility name, and drawings of alternate.

- E **Leave blank. When returned by OSHPD, staff action taken will be indicated.**

- F **Leave blank. When returned by OSHPD, staff action taken will be indicated.**